Mount Pleasant Baptist Church

2516 Squirrel Hill Road ▪ Herndon, VA 20171
Phone: (703) 793-1196 ▪ Fax: (703) 793-1197
www.mtpleasantbaptist.org

Pastor: Rev. Dr. James L. Graham, Jr.

Christian Camp
The C.R.O.S.S.
APPLICATION FOR ENROLLMENT

Child's Name: ____________________ ____________________ _____________________
Last *First* *Middle*

Birth Date:___________ Age: _______ Gender: ___________Grade this Fall:________

Child's Social Security Number: ______________________ **T-Shirt Size: S M L XL**

Home Address: ____

City: ______________________________ State: ______________ Zip: _______________

Does your child have any special academic needs? [] Yes [] No If yes, please explain.____
____

(Registration)
Payment Schedule: [] Session-1 Due: March 3 [] Session-2 Due: April 21

Registration Fee: $25.00 per session (Non – refundable)

Date Received: _________ Check #: _________

Payment Schedule:	[] Session-1 Due: April 3	[] Session-2 Due: May 5
	June 23 thru July 18	July 21 thru August 15
	6:30 a.m. to 6:00 p.m. (M-F)	6:30 a.m. to 6:00 p.m. (M-F)
	$575.00	$575.00
	Date Received: ___________	Date Received: ____________
	Check #:________________	Check #:_________________

*****Please make checks payable to*: Mt. Pleasant Baptist Church******
(Note Area: Christian Camp/Child's Name)

Family Information (Confidential)

Father's Name: ____________________ ____________________ ____________________
First *Middle* *Last*

Employer: ____________________________ Work Phone: ________________________

Pager#: ___________________________ Cell Phone: _____________________________

Email Address: ____

Mother's Name: _________________ ___________________ ______________________
First *Middle* *Last*

Pager#: __________________________ Cell Phone: _____________________________

Email Address: ____

Marital Status of Parents: [] Married [] Separated [] Divorced [] Other ___________

Persons Authorized to pick up child/children:

1.___________________ ________________________ ________________
Name *Relationship* *Phone#*

2.___________________ ________________________ ________________
Name *Relationship* *Phone#*

3. ___________________ ________________________ ________________
Name *Relationship* *Phone#*

In signing the application form; parents enroll their children with the understanding that the administration may request the withdrawal of any child/children at any time, if in the administration's opinion that the child, and /or parents,/guardian does not uphold a spirit of willing compliance with the overall MPBCCC philosophy.

"I have read and agree to cooperate with the standards and policies of Mount Pleasant Baptist Church Christian Camp."

Signature: ____ Date: ___________

(*Parents must sign for application to be processed. A non-refundable fee must accompany this application.)*

MT. PLEASANT BAPTIST CHURCH'S CHRISTIAN SUMMER CAMP MEDICAL/EMERGENCY INFORMATION:

In the event of an emergency, Mt. Pleasant Christian Camp will attempt to contact a child's parent/guardian. However, in the event that we are unable to reach you, we will contact one of the alternate emergency contacts on your list.

1. **Please list names and phone number of parents/guardians.**

_______________	_______________	_______________	_______________
Mother's Name	Home Phone	Business Phone	Cell/Pager
_______________	_______________	_______________	_______________
Father's Name	Home Phone	Business Phone	Cell/Pager
_______________	_______________	_______________	_______________
Guardian's Name	Home Phone	Business Phone	Cell/Pager

2. **In case of accident or illness, I request that MPBCCC contact me. If MPBCCC is unable to reach me, the following persons will be responsible for my child's transportation and care.**

_______________	_______________	_______________	_______________
Name	Relationship	Home phone	Business phone
_______________	_______________	_______________	_______________
Name	Relationship	Home phone	Business phone

3. **In case of an emergency requiring immediate medical attention, your child will be taken to the nearest hospital emergency room. Your signature authorizes MPBCCC to obtain medical care deemed necessary for your child in the event that you cannot be located immediately.**

_______________	_______________	_______________
Phy*sician's Name*	*Physician's Phone*	*Health Insurance Provider*
_______________	_______________	_______________
Phone Number	*Policy Holder's Name*	*Policy Number*

4. Does your child have a history of:

Fainting with exercise? [] Yes [] No ___________________________
Losing consciousness after an injury? [] Yes [] No ___________________________
Seizures? [] Yes [] No___________________________
Diabetes? [] Yes [] No___________________________
Heart problems (chest pain, murmur etc.)? [] Yes [] No ___________________________
Allergies (food, medicine, pollen etc.)? [] Yes [] No ___________________________
Does your child carry an inhaler? [] Yes [] No ___________________________
Does your child have ear problems? [] Yes [] No ___________________________
Does your child wear glasses? [] Yes [] No ___________________________
Had any previous surgery? [] Yes [] No ___________________________

5. Does your child take any medications regularly? [] Yes [] No

1) Medication: ____

Dosage: ____

2) Medication: ____

Dosage: ____

I/we authorize and consent to any life saving treatment, and hospital care that, in the best judgment of a licensed physician or dentist is deemed advisable. I/we agree to assume the financial responsibility for all expenses incurred as a result of those services being provided. I/we also agree to be financially responsible for emergency medical transportation.

____ ____________________

Parent/Guardian Signature **Date**